

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 11/19/03.

I. DISPUTE

Whether there should be additional reimbursement for CPT code E1399 (Durable Medical Equipment-RS4i Muscle Stimulator) for date of service 8/10/03. Amount billed was \$250.00. Payment received, \$150.00. Disputed amount \$100.00.

II. RATIONALE

The service in dispute was denied as, "F-Z560-The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix."

Requestor states that, "There is no established fee schedule for this device."

Carriers' statement of position dated 12/8/03 states in part, "According to the Texas Medical Fee Guideline page 254, section IX, paragraph C, reimbursement shall be an amount pre-negotiated between the provider and the carrier or if there is no pre-negotiated amount, the fair and reasonable rate. Documentation is provided to show that this is the rate that Liberty Mutual routinely and consistently reimburses for stimulator rental."

There is no Maximum Allowable Reimbursement for CPT E1399. Per Commission Rule 133.307 (g)(D) states, in part, "...if the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code §413.011...".

The Requestor submitted one properly redacted EOB in support of their request for reimbursement per Rule 133.307 (E). The Respondent submitted four different appropriately redacted EOB's in support of their rate of reimbursement in the amount of \$150.00 per month for rental of miscellaneous durable medical equipment. Based on review of relevant information submitted by the Respondent, Medical Dispute Resolution has determined no additional reimbursement is due.

III. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 08th day of March 2004.

Terri Chance
Medical Dispute Resolution Officer
Medical Review Division

TC/tc